BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

RAY VOIERS Claimant	)	
VS.	)	
MIDWAY SALES & DISTRIBUTING, INC. Respondent	)	Docket No. 1,031,247
AND	)	
CONTINENTAL WESTERN INS. CO. Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Respondent and its insurance carrier (respondent) requested review of the October 31, 2007, Award, and the November 14, 2007, Order entered by Administrative Law Judge Brad E. Avery. The Board heard oral argument on January 23, 2008. George H. Pearson, of Topeka, Kansas, appeared for claimant. Nathan D. Burghart, of Lawrence, Kansas, appeared for respondent.

In the Award entered October 31, 2007, the Administrative Law Judge (ALJ) found that claimant suffered personal injury by a series of accidents from August 30, 2006, through September 15, 2006, which arose out of and in the course of his employment with respondent. The ALJ further found that claimant provided timely notice of his accidental injuries. Giving equal credence to the ratings of Dr. Daniel Zimmerman and Dr. Peter Bieri, the ALJ awarded claimant a 14.5 percent permanent partial impairment to the body as a whole. The ALJ further found that claimant is entitled to future medical care upon application and review and to unauthorized medical care up to the statutory limit. Although not raised as an issue at the regular hearing, the ALJ found that respondent was not entitled to reimbursement by the Workers Compensation Fund for payment of medical bills incurred by claimant from Stormont-Vail Regional Medical Center (Stormont-Vail) and Dr. Michael Smith.

After receiving the ALJ's Award, respondent filed a motion for reconsideration and to include the deposition of Michael Moorhead as a part of the record in the case. Although the deposition of Mr. Moorhead had been taken before the end of respondent's terminal date, the transcript of that deposition was not filed before the ALJ entered the Award. In his Order entered November 14, 2007, the ALJ denied respondent's motion for reconsideration. During oral argument to the Board, the parties agreed that the Moorhead deposition should be considered as part of the record but that a remand to the ALJ was unnecessary as the Board could consider that deposition testimony as part of its de novo review of the ALJ's Award.

The Board has considered the record and adopted the stipulations listed in the Award. In addition, the Board has considered respondent's deposition of Mike Moorhead as part of the record.

ISSUES

Respondent requests review of the nature and extent of claimant's disability, including whether the functional impairment awarded by the ALJ is excessive and contrary to the AMA *Guides*[1]; whether the ALJ erred in ordering respondent to pay for the medical treatment claimant received at Stormont-Vail, including the surgery performed on October 4, 2006; whether claimant gave timely notice of his injury of August 30, 2006; whether claimant suffered personal injury by accident arising out of and in the course of his employment on September 15, 2006, and, if so, should benefits related to that injury date be denied for failure to provide timely notice and timely written claim; and whether claimant was entitled to temporary partial disability benefits. Respondent further contends the ALJ erred in failing to consider the deposition of Mr. Moorhead, but during oral argument to the Board respondent withdrew its request that the Board remand the case to the ALJ for reconsideration in light of that deposition and instead agreed that the Board should take Mr. Moorhead's deposition into consideration in evaluating the issues on appeal.

Claimant argues that claimant was injured on August 30, 2006, and each and every working day through September 15, 2006, and that respondent had timely notice and timely written claim of those accidents. Claimant further contends that respondent did not object to the amendment of claimant's E-1 to claim a series of accidents from August 30, 2006, through September 15, 2006, but only denied the accident and notice. Claimant argues that his hospitalization and surgery were medically necessary and that respondent failed to provide reasonably necessary treatment to claimant after being informed of the impending surgery. Claimant asserts, therefore, that the ALJ correctly ordered respondent to pay the bills related to that hospitalization and surgery as authorized medical expense.

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[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

Claimant also requests the Board affirm the ALJ's finding that claimant suffered a 14.5 percent permanent partial impairment to the body as a whole. Claimant further argues that the issue of temporary partial disability benefits was not raised at the regular hearing and therefore has been waived.

The issues for the Board's review are:

(1) Did claimant suffer a single traumatic personal injury by accident on August 30, 2006, or a series of accidental injuries from August 30, 2006, through September 15, 2006, which arose out of and in the course of his employment with respondent?

(2) Did claimant provide timely notice of his alleged injury of August 30, 2006, or his alleged series of injuries through September 15, 2006?

(3) In the event the Board finds that claimant suffered a series of accidents after August 30, 2006, through September 15, 2006, did claimant provide timely written claim of his series of accidents?

(4) Did the ALJ err in ordering respondent to pay for all of the medical treatment claimant received at Stormont-Vail, including the surgery performed on October 4, 2006, as authorized medical, or was the Stormont-Vail treatment unauthorized and subject to the $500 maximum?

(5) What is the nature and extent of claimant's disability? Was the percentage of functional impairment in the ALJ's Award contrary to the AMA *Guides*?

(6) Is claimant is entitled to temporary partial disability benefits?

DATE OF ACCIDENT/TIMELY NOTICE

FINDINGS OF FACT

Claimant is employed by respondent as a delivery driver operating out of its Lawrence, Kansas, branch. On August 30, 2006, he was "throwing shingles," which consisted of removing bundles of shingles from a pallet and placing them on a conveyor. There are 36 bundles to a pallet, and he was working on the fourth pallet when he twisted his body and felt a pull in his low back. He felt pain across his back right above his belt line. Claimant continued to work the rest of the day and did not report the incident to anyone because he thought the pain would go away.

Claimant contends he first reported his injury to respondent on September 6, 2006. He claims he mentioned his back problems to Joel Dickey, the manager of respondent's Lawrence branch. He admits he did not go into detail about the injury but just said that his back was bothering him and related the pain to his throwing shingles. He did not tell Mr.

Dickey that he thought he needed to see a doctor, and there was no discussion about filling out an accident report. Mr. Dickey did not give any indication that he heard what claimant said, and claimant admits he does not know whether he was heard by Mr. Dickey.

On either September 8 or September 11, 2006, claimant told Mr. Dickey that he had an appointment with a chiropractor on September 14. Claimant testified that Mr. Dickey told him that if he could not get in to see the chiropractor on September 14, he should let him know and he would try to get him into Promptcare. Claimant did not mention during that conversation that his back condition was caused by throwing shingles because he assumed it would be understood that he wanted to see the chiropractor for his work injury. Claimant planned to pay the chiropractor's bill himself. The September 14 appointment was later cancelled by the chiropractor.

On September 15, 2006, claimant was again working throwing shingles, and it made his back pain worsen to the point that he could barely walk. When his truck was unloaded, he had trouble getting into the cab of the truck. When he and his coworker returned to respondent's warehouse, he had trouble getting back out of the truck. At that time, Mr. Dickey sent him to Promptcare for treatment.

Claimant said he could not recall any incidents between August 30 and September 15 where he felt a pull or a pop such as happened on August 30. At the preliminary hearing, he was asked:

> Q. [by respondent's attorney] . . . [A]re you saying that you had another injury on the 15th?
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> A. [by claimant] No, I'm not saying that. I'm just saying my back felt worse on the 15th than it did on [the] 30th.
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> Q. So your symptoms were worse on the 15th than on the 30th?
>
> A. Yes.[2]

When claimant returned from treatment on September 15, he and Mr. Dickey filled out an accident report listing a date of accident of August 29, 2006.[3] Claimant continued to work with restrictions from Promptcare. From September 15 through September 25, claimant worked light duty and did not throw any bundles of shingles.

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[2] P.H. Trans. at 109-10.

[3] Claimant believes he told Mr. Dickey that his date of accident was August 30, 2006, and does not know why the accident report listed a date of accident of August 29, 2006. P.H. Trans. at 56.

Mr. Dickey testified that he was first notified by claimant that he had suffered a work-related injury on September 15, 2006. He did not recall a conversation with claimant on September 6 concerning his back.

After the preliminary hearing held December 12, 2006, the ALJ found that claimant suffered a series of accidental injuries through September 15, 2006, and that claimant gave timely notice of his injuries. Those issues were appealed to the Board. On March 16, 2007, a Board Member affirmed the ALJ, finding that "it is more likely true than not true that claimant's low back injury resulted from a series of repetitive traumas."[4] The Board Member also found that the requirement of timely notice was satisfied.

In the ALJ's Award entered October 31, 2007, the ALJ stated:

> The record of regular hearing contains no additional evidence which would lead the court to reverse or modify its previous decision. The court would note the medical opinions admitted after the regular hearing use the date of the accident of either August 30, 2006 or August 26, 2006. However, the claimant's testimony at preliminary hearing clearly indicate he suffered one event in August and aggravated his condition on September 15, 2006.[5]

The ALJ further found that "claimant provided timely notice of an accidental injury."[6] [Emphasis added.]

PRINCIPLES OF LAW

K.S.A. 2006 Supp. 44-508(d) states in part:

> "Accident" means an undesigned, sudden and unexpected event or events, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. The elements of an accident, as stated herein, are not to be construed in a strict and literal sense, but in a manner designed to effectuate the purpose of the workers compensation act that the employer bear the expense of accidental injury to a worker caused by the employment. In cases where the accident occurs as a result of a series of events, repetitive use, cumulative traumas or microtraumas, the date of accident shall be the date the authorized physician takes the employee off work due to the condition or restricts the employee from performing the work which is the cause of the condition. . . . Nothing in this subsection shall be construed to preclude a worker's

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[4] *Voiers v. Midway Wholesale*, No. 1,031,247, 2007 WL 1041061 (Kan. WCAB March 16, 2007).

[5] ALJ Award (Oct. 31, 2007) at 2.

[6] *Id.* at 3.

right to make a claim for aggravation of injuries under the workers compensation act.

K.S.A. 44-520 states:

> Except as otherwise provided in this section, proceedings for compensation under the workers compensation act shall not be maintainable unless notice of the accident, stating the time and place and particulars thereof, and the name and address of the person injured, is given to the employer within 10 days after the date of the accident, except that actual knowledge of the accident by the employer or the employer's duly authorized agent shall render the giving of such notice unnecessary. The ten-day notice provided in this section shall not bar any proceeding for compensation under the workers compensation act if the claimant shows that a failure to notify under this section was due to just cause, except that in no event shall such a proceeding for compensation be maintained unless the notice required by this section is given to the employer within 75 days after the date of the accident unless (a) actual knowledge of the accident by the employer or the employer's duly authorized agent renders the giving of such notice unnecessary as provided in this section, (b) the employer was unavailable to receive such notice as provided in this section, or (c) the employee was physically unable to give such notice.

ANALYSIS AND CONCLUSION

The Board finds claimant suffered a series of accidents and injuries each day he worked from August 30, 2006, through September 15, 2006. Because claimant's accident occurred as a result of a series of events, for purposes of K.S.A. 2006 Supp. 44-508(d), the date of accident is the date the authorized physician restricted claimant from the work which was the cause of his condition, in this case heavy lifting and throwing shingles. Respondent authorized claimant to obtain treatment from the physician at PromptCare on September 15, 2006, and claimant was given light duty restrictions on that date. Thereafter, claimant did not throw bundles of shingles at work. Accordingly, claimant's date of accident was September 15, 2006. Respondent admits claimant gave his supervisor, Mr. Dickey, notice of accident on September 15, 2006. Therefore, notice was timely. For purposes of K.S.A. 44-520, it does not matter that claimant failed to specifically say that he was injured by a series of accidents or that claimant gave the beginning date rather than the ending date of his series of accidents. The intent of the notice statute was satisfied when claimant told respondent of his work-related injury on September 15, 2006. Although claimant mistakenly said to Mr. Dickey on September 15, 2006, that his injury occurred on August 29, 2006, Mr. Dickey was obviously aware that claimant's injury had worsened because by that date, September 15, 2006, claimant could no longer work and was sent to the doctor.

The Board finds claimant gave timely notice of his September 15, 2006, accident. The ALJ's findings and conclusions are affirmed.

TIMELY WRITTEN CLAIM

FINDINGS OF FACT

Claimant's Application for Hearing was filed with the Division on October 4, 2006. It sets out a date of accident of August 30, 2006. At the preliminary hearing, claimant's attorney requested that he be allowed to amend the date of accident to claim a "series of repetitive movements and lifting strains from August 30, 2006 through September 15, 2006 . . . ."[7] Respondent's attorney stated: "We would deny any series of accidents . . . arising out of employment."[8] Claimant did not file an amended Application for Hearing setting out a date of accident to be a series through September 15, 2006. Respondent argues it has not received a written claim for a series of accident through September 15, 2006.

At the regular hearing, the ALJ set out the issues to be decided by the court to be:

> . . . whether the claimant suffered personal injury or injury by accident, whether the accidental injury arose out of and occurred in the course of employment and whether the claimant provided the respondent timely notice. Nature and extent of disability and future and unauthorized medical care. Any additions, modifications or corrections to that record before we get started?
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> [Claimant's attorney]: No, Your Honor.
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> [Respondent's attorney]: No, Your Honor.[9]

No submission letter was filed by either party listing timely written claim as an issue in this case. The ALJ did not rule on the issue of timely written claim for a date of accident of September 15, 2006.

PRINCIPLES OF LAW

K.S.A. 44-520a(a) states:

> No proceedings for compensation shall be maintainable under the workmen's compensation act unless a written claim for compensation shall be served upon the employer by delivering such written claim to him or his duly authorized agent, or by delivering such written claim to him by registered or certified mail within two hundred (200) days after the date of the accident, or in cases where

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[7] P.H. Trans. at 17.

[8] *Id.* at 18.

[9] R.H. Trans. at 5-6.

> compensation payments have been suspended within two hundred (200) days after the date of the last payment of compensation; or within one (1) year after the death of the injured employee if death results from the injury within five (5) years after the date of such accident.

K.S.A. 2006 Supp. 44-555c(a) states in part:

> There is hereby established the workers compensation board. The board shall have exclusive jurisdiction to review all decisions, findings, orders and awards of compensation of administrative law judges under the workers compensation act. The review by the board shall be upon questions of law and fact as presented and shown by a transcript of the evidence and the proceedings as presented, had and introduced before the administrative law judge.

The statute mandates that the Board's consideration be on issues presented to the ALJ. Issues not raised before the ALJ cannot be raised for the first time on appeal. To hold otherwise would place the Board in the position of attempting to decide an issue based upon an incomplete record and would deny claimant the benefit of evidence that may have been presented if he had been aware that there was a dispute as to such issue at preliminary hearing.[10]

ANALYSIS AND CONCLUSION

At the December 12, 2006, preliminary hearing, claimant orally amended his claim for compensation to allege a series of accidents through September 15, 2006. Respondent did not object. At the regular hearing held on August 20, 2007, the ALJ announced that the "alleged accident date is 9/15/06."[11] The ALJ also stated the issues to be decided by the court. Whether claimant served a timely written claim upon respondent or whether the amended alleged accident date would relate back to the date the original application for hearing was filed were not raised as issues at the regular hearing or otherwise before the ALJ. Accordingly, the Board will not decide those issues for the first time on appeal.

CLAIMANT'S HOSPITALIZATION AT STORMONT-VAIL

FINDINGS OF FACT

Respondent authorized claimant to be treated by Lawrence Promptcare on September 15, 2006. Claimant admits when he went to Lawrence PromptCare on Friday, September 22, he told Promptcare personnel that he was feeling better that day. But

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[10] See *Scammahorn v. Gibraltar Savings & Loan Assn.*, 197 Kan. 410, 415, 416 P.2d 771 (1966).

[11] R.H. Trans. at 4.

claimant explained that this was probably because he had not been doing any physical work. At that time, Lawrence PromptCare changed his restrictions to allow him to go back to driving and operating a forklift. On Monday, September 25, claimant operated a forklift at work.

Claimant took off work on September 26 to take his pregnant wife to the hospital. He said that after sitting in the hospital for awhile, his back got very stiff. On September 27, he again took off work. He stated that he woke up and could barely walk. His back was stiff, and his legs were numb and tingling. On September 28, his mother-in-law called someone at respondent's Lawrence branch and reported claimant's condition. Someone from respondent later returned claimant's mother-in-law's call and told her that an appointment had been made for him that afternoon at the Kansas Rehabilitation Hospital.

Claimant's mother-in-law, wife, and child took claimant to the Kansas Rehabilitation Hospital on September 28. When they arrived, claimant's mother-in-law went inside the facility to request help getting claimant out of the car. Two employees of the Kansas Rehabilitation Hospital came out to help. They asked claimant how much pain he was in, and he answered he was hurting severely. One of the employees told claimant that he needed to go to the emergency room. Claimant does not know the names of those employees or whether they were nurses or therapists.

Claimant was then taken to Stormont-Vail's emergency room. On the way to the emergency room, claimant's wife called respondent's Lawrence branch to let them know claimant was on his way to the hospital. At the emergency room, x-rays and MRIs were taken, and claimant was admitted into the hospital. The next day, September 29, Dr. Michael Smith, a board certified orthopedic surgeon, began treating claimant. At that time, claimant was complaining of weakness and numbness in his legs. Dr. Smith diagnosed him with a herniated disc at L4-5, which had been confirmed by an MRI.

When Dr. Smith saw claimant on September 29, 2006, he gave him the option of returning home. However, claimant believed that his weakness, numbness and discomfort prevented him from going home. Dr. Smith testified he would have allowed claimant to return home on September 29 if claimant had felt comfortable enough to go home and could manage at home. Nevertheless, he believed that claimant's hospitalization was medically necessary.

While hospitalized, claimant was given a cortisone injection, anti-inflammatories, and pain medication, which were ineffective. Dr. Smith and claimant then made the decision to perform surgery, which was scheduled for October 4, 2006. The purpose of the surgery was to take the pressure off of the nerves by removing the herniated disc. Dr. Smith testified:

> I felt that [claimant] had complaints of weakness and numbness in his legs, significant discomfort. On exam his legs seemed weak. His pain seemed more

> than what you might have expected for a herniated disc. Most herniated discs don't come into the hospital like this. So my feeling was that I needed to take what he was saying as accurate and the exam as accurate, although it is hard sometimes when people are in a lot of pain. He'd been in the hospital for several days and was continuing to have complaints, and I visited with him, and it was my feeling that the weakness and the numbness were real. And I felt that surgery gave him the best opportunity at recovery with limiting any permanent impairment.[12]

Dr. Smith believed that surgery was warranted to minimize any permanency of damage. Dr. Smith, however, agreed that claimant could have waited a week or two before undergoing the surgery or could have elected not to even have the surgery. Claimant admitted that Dr. Smith did not tell him that his surgery was considered emergency surgery. But Dr. Smith told him that if he did not have the surgery right away, he could get worse and more permanent damage could occur.

Claimant admits that the first time he personally spoke to anyone at respondent about his hospitalization was on Monday, October 2, when he called respondent's human resource manager, Lloyd Fleming, informing him that he had been admitted to Stormont-Vail and had been scheduled for surgery. Claimant testified that Mr. Fleming indicated he would call Mr. Moorhead, the claims adjuster for respondent's insurance carrier. Claimant then called Mr. Moorhead himself, telling him he was in the hospital and that Dr. Smith wanted to perform surgery. Claimant testified that Mr. Moorhead told him he would look into the matter and take care of it. Claimant understood that to mean that he was approved to have the surgery. He testified he would not have had the surgery on October 4 if he did not think it had been approved.

Larry Morris is the Revenue Cycle Director at Stormont-Vail. One of the duties of his office is to check to see whether a patient's insurance carrier will authorize specific treatment. Mr. Morris' office maintains log notes reflecting when someone contacts an insurance company. Those notes indicate that an employee of his office contacted Continental Western Insurance Company (Continental Western), respondent's insurance carrier, on September 29, 2006. No authorization for treatment of claimant was received by Stormont-Vail from Continental Western or from respondent. There is no record, other than the conversation of September 29 with Continental Western, of any other attempt made by Stormont-Vail to obtain authorization for the treatment of claimant. Stormont-Vail has a policy of communicating to the patient information that an insurance company has denied authorization for treatment. However, Mr. Morris said claimant was not told that his hospitalization and treatment had been denied by respondent. There is no record that any of the treatment itemized in Stormont-Vail's bill was authorized by respondent or Continental Western.

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[12] Smith Depo. at 28.

Jennifer Turner, who works in one of the departments that Mr. Morris directs, was the person who contacted Continental Western on September 29, 2006. Ms. Turner's affidavit states that on September 29, 2006, "[a] representative of Continental Western Insurance Company informed me that [claimant's] workers' compensation file had been closed and that a new claim would have to be opened."[13] The affidavit further states: "Neither [claimant's] employer nor Continental Western Insurance Company authorized either [claimant's] hospitalization at Stormont-Vail Regional Health Center or the surgical procedure performed October 4, 2006."[14]

Michael Moorhead, claims adjuster for Continental Western, spoke with claimant on October 3, 2006, after claimant had been hospitalized. He testified that he did not authorize claimant to remain in the hospital at Stormont-Vail and did not tell claimant that Continental Western would pay for that hospitalization. Nor did he authorize the surgery performed by Dr. Smith.[15]

PRINCIPLES OF LAW

K.S.A. 2006 Supp. 44-510h states in part:

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.
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> . . . .
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> (b)(2) Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500. The amount allowed for such examination, diagnosis or treatment shall not be used to obtain a functional impairment rating. Any medical opinion obtained in violation of this prohibition shall not be admissible in any claim proceedings under the workers compensation act.

K.S.A. 44-510j(h) provides in part:

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[13] Stipulation filed October 24, 2007, at 2.

[14] *Id.*

[15] Moorhead Depo. at 10-11.

> If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director.

ANALYSIS AND CONCLUSION

Whether the costs for the treatment claimant received at Stormont-Vail should be ordered paid as authorized medical expenses or instead were unauthorized and, therefore, subject to the $500 maximum is not an issue that was raised at the regular hearing or presented to the ALJ. Nevertheless, if the Board were to address this issue, as the ALJ did, the Board would affirm the ALJ's findings and conclusion that the treatment was reasonable, necessary, and should be paid by respondent as an authorized medical expense. In addition to the reasons given by the ALJ, the Board would also find that claimant was referred to the emergency room of the hospital by personnel at the authorized provider, Kansas Rehabilitation Hospital.

NATURE AND EXTENT/AMA *GUIDES*

FINDINGS OF FACT

Dr. Daniel Zimmerman, a board certified independent medical examiner, saw claimant on April 16, 2007, at the request of claimant's attorney. Claimant reported to him that he had been injured lifting shingles and twisting his back at the same time on August 26, 2006. Claimant had a laminectomy at L4-5 with excision of the disc performed by Dr. Smith. Upon examination, Dr. Zimmerman found that claimant had range of motion restrictions at the lumbar level, radicular weakness in each lower extremity, and findings consistent with a lateral femoral cutaneous nerve entrapment syndrome. Dr. Zimmerman opined that the cause of claimant's condition was his work-related injury.

Based on the AMA *Guides,* using the range of motion model, Dr. Zimmerman rated claimant as having a 10 percent permanent partial impairment of the body as a whole because of the surgical procedure for lumbar disc disease. In addition, because of his range of motion restrictions, claimant was rated as having a 2 percent permanent partial impairment to the body as a whole. Due to weakness in both legs in toes two through five, Dr. Zimmerman rated claimant with a 7.4 percent permanent partial impairment to each lower extremity, which converts to 3 percent of the body as a whole for each leg. For the lateral femoral cutaneous nerve entrapment syndrome, claimant was rated as having a 4.2 percent permanent partial impairment of the leg, which converts to 2 percent to the body as a whole. Using the Combined Values Chart, claimant had a 19 percent permanent partial impairment to the body as a whole.

Dr. Zimmerman acknowledged that under the DRE model of the AMA *Guides*, claimant would have only had a 10 percent permanent partial impairment of the body as

a whole. But Dr. Zimmerman believed claimant has significant limitations as a result of his injury and the range of motion model more fairly represents the total residuals he has sustained. The DRE model would not have addressed the weakness found in claimant's legs, the left lateral femoral cutaneous nerve entrapment syndrome, or the decreased range of motion.

Dr. Zimmerman stated that the only two times there is an emergency situation for lumbar intervertebral disc surgery is if there is progressive weakness like a slap foot developing, or if the individual is developing cauda equina syndrome. Dr. Zimmerman has no evidence that claimant was developing a slap foot or cauda equina syndrome.

Dr. Zimmerman stated that claimant's degenerative disc disease is responsible for his lateral femoral cutaneous nerve entrapment syndrome. The degeneration more than likely preexisted claimant's accident. However, the degeneration may have been aggravated.

Claimant was seen on September 18, 2007, by Dr. Peter Bieri, an independent medical examiner, at the request of the ALJ. Claimant complained of persistent low back pain radiating into the right lower extremity. He reported intermittent numbness and tingling on the right into the toes. Claimant told Dr. Bieri that he had pain at night and that he has an intolerance to sitting and driving after 45 to 60 minutes.

Dr. Bieri found that claimant's injury occurred during the course of his employment with respondent on or about August 30, 2006, and involved the low back with a diagnosis of herniated nucleus pulposus to the right at L4-5, with radiculopathy. Dr. Bieri found that diagnoses and treatment to date were reasonable, appropriate and consistent. Dr. Bieri found claimant to be at maximum medical improvement.

Based on the AMA *Guides*, DRE model, Dr. Bieri found that claimant had a 10 percent permanent partial impairment to the body as a whole. He opined that claimant met the general physical demand level defined as light-medium and recommended claimant restrict occasional lifting to 40 pounds, frequent lifting not to exceed 20 pounds, and no more than 10 pounds of constant lifting. Twisting and bending should be performed no more than occasionally to frequently.

PRINCIPLES OF LAW

K.S.A. 44-510e(a) states in part:

> (a) If the employer and the employee are unable to agree upon the amount of compensation to be paid in the case of injury not covered by the schedule in K.S.A. 44-510d and amendments thereto, the amount of compensation shall be settled according to the provisions of the workers compensation act as in other cases of disagreement, except that in case of temporary or permanent partial

> general disability not covered by such schedule, the employee shall receive weekly compensation as determined in this subsection during such period of temporary or permanent partial general disability not exceeding a maximum of 415 weeks. . . . In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

ANALYSIS AND CONCLUSION

The Board finds the opinions of both Drs. Zimmerman and Bieri to be credible. Both doctors describe their ratings to be consistent with the AMA *Guides*. The Board agrees with the ALJ's determination that claimant's permanent impairment lies somewhere in the range of percentages given by the two physicians and, therefore, agrees with the ALJ's decision to average the two ratings. Claimant's functional impairment is 14.5 percent, and he is entitled to an award of permanent partial disability compensation based upon that impairment percentage.

TEMPORARY PARTIAL DISABILITY BENEFITS

FINDINGS OF FACT

Claimant returned to work full time as of October 23, 2006, although he had restrictions allowing him to only work sedentary tasks with no sitting, walking or standing for any length of time. He was earning the same hourly rate of pay as he was before being hospitalized. Although he was not aware that any doctor had restricted the number of hours he could work, he did not work any overtime during the period from October 23, 2006, until he was released from treatment by Dr. Smith on March 9, 2007. Before his hospitalization, claimant regularly worked a considerable amount of overtime. Before claimant was given sedentary work restrictions after his surgery, he was averaging $222.17 per week in overtime pay. At the preliminary hearing, claimant was asked whether his sedentary work restrictions were the reason he was not getting overtime, and claimant answered: "I don't know the reason why I'm not getting overtime."[16]

In February 2007, claimant had a functional capacity examination, after which his restrictions were changed and he was able to lift up to 75 pounds and was able to drive a forklift and a truck. Thereafter, he was able to do the work he did before his injuries. Dr. Smith released claimant from treatment on March 9, 2007, at which time he found claimant to be at maximum medical improvement.

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[16] P.H. Trans. at 107.

Respondent paid claimant temporary partial disability at the rate of $148.12 per week beginning October 23, 2006. Temporary partial disability benefits were paid to March 9, 2007, in the total amount of $2,962.40. Respondent argues that because claimant returned to work for respondent full time on October 23, 2006, and because no doctor had restricted the number of hours he was to work, he was not entitled to temporary partial disability benefits.

As with the issue concerning timely written claim, this issue was not raised at the time of the regular hearing, nor was any submission letter filed by either party listing temporary partial disability benefits as an issue to be decided by the ALJ.

PRINCIPLES OF LAW

K.S.A. 44-510e(a) provides, in part:

> . . . Weekly compensation for temporary partial general disability shall be 66⅔% of the difference between the average gross weekly wage that the employee was earning prior to such injury as provided in the workers compensation act and the amount the employee is actually earning after such injury in any type of employment, except that in no case shall such weekly compensation exceed the maximum as provided for in K.S.A. 44-510c and amendments thereto.

The Act does not specifically define when temporary partial disability exists. But K.S.A. 44-510e(a) does define permanent partial disability as being "disabled in a manner which is partial in character and permanent in quality." Therefore, by implication, temporary partial disability exists when a worker is disabled in a manner which is partial in character and temporary in quality.

Like temporary total disability compensation, temporary partial disability compensation is intended solely as wage replacement. In this respect, temporary partial disability compensation is akin to temporary total disability compensation, as opposed to permanent partial disability compensation. The calculation for temporary total disability compensation is, likewise, tied to the average gross weekly wage that the employee was earning prior to his injury. K.S.A. 44-510c(b)(1) provides:

> Where temporary total disability results from the injury . . . weekly payments shall be made during such temporary total disability, in a sum equal to 66 2/3% of the average gross weekly wage of the injured employee, computed as provided in K.S.A. 44-511 and amendments thereto . . . .

Issues not raised before the ALJ cannot be raised for the first time on appeal.[17]

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[17] See K.S.A. 2006 Supp. 44-555c(a); *Scammahorn, supra* note 10.

ANALYSIS AND CONCLUSION

Whether claimant is entitled to temporary partial disability compensation was not raised as an issue by either party at the regular hearing, nor was it otherwise presented as an issue to the ALJ. Accordingly, the Board will not address that issue in this review.

Finally, the Board notes that the ALJ ordered claimant's counsel to submit his attorney fee contract with claimant for approval. The record does not contain a fee agreement between claimant and his attorney. K.S.A. 44-536(b) requires that the Director review such fee agreements and approve such contract and fees in accordance with that statute. Should claimant's counsel desire a fee be approved in this matter, he must submit his contract with claimant to the ALJ for approval.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Brad E. Avery dated October 31, 2007, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of February, 2008.

_____
BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: George H. Pearson, Attorney for Claimant
Nathan D. Burghart, Attorney for Respondent and its Insurance Carrier
Brad E. Avery, Administrative Law Judge